Students cannot register for classes until they have fulfilled the immunization and meningitis information requirements.
This form must be completed and signed by a medical provider, can attach immunization records from previous school, medical provider or government agency. Exemption information can be reviewed at buffalo.edu/studentlife/immunize

2018-2019 Health Background Form

All students: undergraduate, graduate, and professional

University at Buffalo Student Health Services
Michael Hall, 3435 Main Street, Buffalo, NY 14214-8003
Phone: 716-829-3316 Fax: 716-829-2564

Name (please print): _____ UB Person #: _____
Last First MI

Birthdate: ____/____/____ Academic Program/Major: _____
Month Day Year

Emergency contact name & phone #: _____

For Students Under 18 Years of Age Only

To avoid delay in treatment when medical problems arise, we request that the following statement be signed by a parent or legal guardian:
I hereby grant permission to the medical providers and nurses of the University at Buffalo Student Health Services to evaluate and treat my son/daughter/ward in case of illness/injury. I also hereby grant permission to immunize my son/daughter/ward in cases where immunization is necessary as part of a treatment plan or when needed for prevention of illness.

_____ _____ _____
Parent/Guardian Signature Relationship Date

Part 1 Immunizations Required for ALL STUDENTS

MMR (Measles, Mumps, Rubella) ***REQUIRED***

Immunization	Immunization Date (Month/Day/Year)	*Or* Attach Serology Results/Date
2 MMR's (measles, mumps & rubella) 1st dose after 1st birthday; 2nd dose at least 28 days later OR individual immunizations below	#1	
	#2	
2 MEASLES 1st dose after 1st birthday; 2nd dose at least 28 days later	#1	In order for serology to be considered during compliance review, lab report documenting positive titer(s) must be attached.
	#2	
1 MUMPS after 1st birthday		
1 RUBELLA after 1st birthday		

Meningitis Information Form ***REQUIRED***

New York State Public Health Law requires all students to verify that they have received information about meningococcal disease and made an informed decision about immunization. Review this information at buffalo.edu/studentlife/immunize

You must complete one of the following:

Meningitis ACWY (within 5 years)	**Vaccination Date:** _____
Meningitis WAIVER	I acknowledge the risks associated with meningitis and refuse immunization. _____ Student sign & date if 18 years of age or older; Parent/guardian sign & date if under 18 years of age

Part 2 Immunizations Required for HEALTH-RELATED STUDENTS Optional for all other students

*Students enrolled (not *intended*) in health-related programs are **required** to provide proof of PPD (see Part 4C), Tetanus (within 10 years), and Hepatitis B and Varicella immunity.

Positive titers are an acceptable substitute for Hepatitis B and/or Varicella immunization dates: Lab report documenting positive titer(s) must be attached.

Immunization	Immunization Date(s) (Month/Day/Year)		
Hepatitis B*	#1	#2	#3
Tetanus* Within 10 years. Complete both fields even if date is the same	Date of most recent Tetanus and circle type: Circle: Td Tdap	Date of 1 lifetime, adult Tdap (pertussis booster):	
Varicella*	#1	#2	**Or** date of clinician diagnosis

Part 3 Additional Immunizations Optional for ALL STUDENTS

Immunization	Immunization Date(s) (Month/Day/Year)		
Hepatitis A	#1	#2	
Human Papilloma (HPV)	#1	#2	#3

An official stamp and/or an authorized signature from a medical provider must appear on this form or it will not be accepted.

_____ _____
Signature/Stamp of medical provider **Date**

_____
Phone number of medical practice

Name (please print): _____ UB Person #: _____
Last First MI

Country of Birth: _____ Year arrived in US: _____

Part 4 Tuberculosis Screening Sections A & B Required for ALL STUDENTS; Section C is Required as Directed in Sections A & B

SECTION A:

1. Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT? **YES ☐ NO ☐**
If yes, please provide details in Section C below.

SECTION B:

1. Are you currently enrolled (**not *intended***) in a health-related program (Athletic Training, Dental, Dietetic Intern, Exercise Science, Medicine, Med Tech/Bio Tech, Nuclear Med, Nursing, OT, Pharmacy, PT)? **YES ☐ NO ☐**
2. Were you born in, or have you lived, worked or visited for more than one month in any of the following: Asia, Africa, South America, Central America or Eastern Europe? **YES ☐ NO ☐**
   If yes, what country? _____ How long? _____
3. Do any of the following conditions or situations apply to you?
   a) Do you have a persistent cough? (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? **YES ☐ NO ☐**
   b) Have you ever lived with or been in close contact to a person known or suspected of being sick with TB? **YES ☐ NO ☐**
   c) Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility? **YES ☐ NO ☐**

Student Signature _____ Date _____

If you answered no to all of the above questions, skip Section C.
If you answered yes to any of the above questions, your medical provider must complete Section C below.

SECTION C: ATTENTION MEDICAL PROVIDER: If patient answered YES to any of the above questions, a TB test (PPD, T-Spot , or TB QuantiFERON) is REQUIRED. History of BCG vaccination does not exclude patient from this requirement. Test must be done within one calendar year (unless history of positive TB test). If PPD results are 10mm or more, or T-Spot or TB QuantiFERON are positive, a chest x-ray is REQUIRED. For students with history of positive TB test, documentation of dates & results of testing and chest x-ray, as well as treatment information, must be documented below. It is not necessary for these students to repeat TB testing or CXR.

PPD Date Placed:	PPD Date Read:	Measurement in mm induration:
OR		
QuantiFERON-TB Gold or T-Spot Result Date:	QFT-G or T-Spot Result: Positive Negative Equivocal **Circle and attach lab report**	

If PPD results are 10mm or more, or QuantiFERON-TB Gold or T-SPOT results are positive, a chest x-ray is REQUIRED.

Chest X-Ray Date:	Chest X-Ray Result:

If negative CXR and positive PPD/Lab Result, did the patient complete a course of INH or other TB Treatment? YES ☐ NO ☐

If yes, name & dose of medication: _____

Date Range of Treatment: _____ **How many months did student take medication?** _____ **(# of months)**

PROVIDER INFORMATION REQUIRED

_____ _____ _____
Signature/Stamp of health care provider Phone number of practice Date

Part 5 Physical Examination Required for 1st Year Dental and 3rd Year Nursing students. Optional for all other students.

Height:_____ Weight:_____ Blood Pressure:_____

Any significant history, physical exam findings, regular medications, or restriction of activity?

_____

_____

_____ _____ _____
Signature/Stamp of medical provider Phone number of practice Date